



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

HOUSTON TX 77030

Requestor Name and Address

FONDREN ORTHOPEDIC GROUP
7401 S. MAIN

Respondent Name

BAPTIST HOSPITALS OF SOUTHEAST

Carrier's Austin Representative Box

Number 19

MFDR Tracking Number

M4-12-3455-01

MFDR Date Received

July 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the request for reconsideration dated June 4, 2012: "...We are requesting reconsideration based on the following: Claim was processed and under paid. Starting in 2012, Code 29826 is now an add on code and is no longer endoscopic. The amount should not have an additional reductions [sic]...The 2012 Texas work comp fee schedule is 359.89..."

Amount in Dispute: \$359.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not respond to this medical fee dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2012	CPT code 29826 RT	\$359.89	\$359.89

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets forth the fee reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanations of benefits

- 59 – Processed based on multiple or concurrent procedure rule...
- W1 – workers compensation jurisdictional fee schedule adjustment
- 607 – reimbursement for this procedure has been calculated according to the multiple procedure rule

Issues

1. Is CPT code 29826 discounted under the multiple procedure rule for the disputed date of service?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." According to Medicare payment policies in effect on the date of service, CPT code 29826 is an 'add-on' code, and is not subject to multiple procedure discounting.
2. 28 Texas Administrative Code §134.203(c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32."
Commissioner's Bulletin #B-0044-11 states, "for services provided in calendar year 2012, the new Medical Fee Guideline conversion factors in 28 TAC §134.203(c) are \$54.86 and \$68.88... The conversion factor of \$68.88 applies to Surgery when performed in a facility setting. The total MAR is as follows: \$68.88 workers compensation conversion factor ÷ 34.0376 Medicare conversion factor x 177.84 participating amount = \$359.89.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$359.89.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$359.89 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March , 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.